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No. 06-614

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

ERIC RUBIN-SCHNEIDERMAN,

Petitioner,

v.

MERIT BEHAVIORAL CARE CORPORATION, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENT EMPIRE BLUE CROSS AND BLUE SHIELD

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QUESTION PRESENTED FOR REVIEW

Whether this Court should grant certiorari in a case in which the only issue of law presented, whether damages may be awarded as relief under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3), has been resolved by long settled ERISA precedent, and as to which there are no conflicts between any courts.

CORPORATE DISCLOSURE STATEMENT

Empire HealthChoice Assurance, Inc., doing business as Empire Blue Cross and Blue Shield, is wholly owned by WellPoint, Inc. through WellPoint Holding Corp. and WellChoice Holdings of New York, Inc. WellPoint, Inc. is a publicly traded company and no publicly held company owns ten percent or more of its stock. Neither Empire HealthChoice Assurance, Inc., WellPoint Holding Corp. nor WellChoice Holdings of New York, Inc. are publicly traded.

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INTRODUCTION

The case presented by Petitioner fails to satisfy any of the criteria for granting certiorari established by this Court in its Rules and in applicable precedent. Rule 10 of the Rules of the Supreme Court of the United States provides that "a petition for a writ of certiorari will be granted *only for compelling reasons*" (emphasis added). Rule 10 further defines the circumstances in which a Writ of Certiorari may be issued as follows: a) a federal court's decision has created a conflict with other federal circuits' rulings on the issue presented, or between a federal and a state court on a question of federal law; b) a state court of last resort has created a conflict with other such state courts or with federal courts on a federal question; or c) a federal appeals court has decided an issue that has not been addressed by this Court or in a way that conflicts with prior decisions of this Court. *See also Braxton v. United States*, 500 U.S. 344, 347 (1991) ("A principal purpose for which we use our certiorari jurisdiction . . . is to resolve conflicts among the United States courts of appeals and state courts concerning the meaning of provisions of federal law."); *Carson v. Am. Brands, Inc.*, 450 U.S. 79, 82-83 (1981).

This case satisfies none of these criteria. The issue presented for review is whether a damages remedy is provided by ERISA to plan participants for a wrongful benefit denial by a plan fiduciary. Petitioner candidly concedes, as he must, that the ruling of the court below, that ERISA does *not* provide a damages remedy, is squarely grounded on Supreme Court precedent, and is wholly in accord with the rulings of all other federal courts on this issue. He seeks to have this Court abandon and reverse its consistent prior precedents in order to create a damages remedy under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3). The sole basis for his argument is that the Court has for decades repeatedly failed to comprehend the true scope of the remedies available in courts of equity that were not adopted from courts of law.

The core fact of this case is that the Petitioner failed to avail himself of the remedy provided by ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), that was specifically crafted by Congress to provide relief to plan participants who believe that they were wrongly denied a claim for benefits. Thus, even if the Petition here satisfied the requirements of Rule 10, and it does not, the threshold question for the Court to resolve would be whether ERISA's remedies set out in Section 502(a) should be amended and a new one created for participants who elect to ignore the statute's existing remedy for improper benefit denials. This threshold question is not a justiciable controversy, as it presents a legislative issue that only Congress has the authority to address and resolve.

STATEMENT OF THE CASE

Statement of Facts

Petitioner Eric Rubin-Schneiderman was covered under a group health policy purchased by an ERISA Health and Welfare Plan (the "Plan") (A-67 – A-131).[1] Empire was the Plan Administrator, and was required in that capacity to determine whether particular health care services for which coverage was sought by Plan members satisfied, among other considerations, the utilization review and management ("UM/UR") standards specified by the Plan's governing documents. Empire had the authority to subcontract the performance of certain of these functions, and contracted with Merit to perform the UM/UR function for the mental health benefits covered by the Plan.

In August 1997, one of Petitioner's treating physicians opined that his mental health condition should be treated in an inpatient psychiatric facility. (A-165, ¶ 8.) Approval for coverage of the proposed admission was requested from Merit. Merit denied the request, through its employee Dr. Ahluwalia, on the ground that inpatient treatment was not a covered Plan benefit

[1] Citations to the record refer to the Joint Appendix filed with the Second Circuit below on January 18, 2006.

in the circumstances presented. (A-178.) Contrary to Petitioner's characterization of this coverage decision, Dr. Ahluwalia and Merit did not "overrule" his treating physician, nor did Dr. Ahluwalia "misdiagnose" Petitioner. (Pet.'s Br. 3, 4.) Dr. Ahluwalia was not Petitioner's treating physician and did not purport to give him medical advice or treatment. She neither could, nor did she, prohibit or bar Petitioner from obtaining the treatment recommended by his treating physician. She only applied the coverage guidelines of Petitioner's ERISA plan and determined that, under the UM/UR guidelines, inpatient treatment was not a covered benefit.

A letter explaining Merit's denial of inpatient treatment was sent to the Petitioner that also informed him of his rights of review and appeal. (A-178.) Neither he, nor anyone on his behalf, pursued the available coverage denial appeal procedures, and no attempt to obtain judicial review of the denial was made. (A- 296.)

Approximately seven months after the denial of coverage, Petitioner apparently attempted to commit suicide. During that seven month period, he was receiving outpatient treatment that was covered by Empire. At no time during those seven months was the request for coverage for inpatient treatment renewed, and no information regarding a worsening of the Petitioner's condition was provided to either Empire or Merit. Petitioner first sought recourse for the benefit denial by later filing a lawsuit for damages.

Procedural History

Petitioner commenced this action on September 29, 2000, some three years after the benefit coverage denial. He filed a state court action asserting various negligence claims against defendants Merit, Ahluwalia, and Empire. Defendants removed the case to the United States District Court for the Southern District of New York and filed separate motions to dismiss the state law claims. Both the removal and the motions to dismiss were predicated on ERISA preemption grounds. Petitioner filed

a motion to remand the case to state court which was denied, and the motions to dismiss were granted on April 9, 2001.

Petitioner then filed an Amended Complaint in the District Court on April 26, 2001, restating his state law claims and asserting ERISA claims under sections 502(a)(1)(A), 502(a)(1)(B) and 502(a)(2), 29 U.S.C. §§ 1132(a)(1)(A), (a)(1)(B), and (a)(2). The relief demanded included damages and attorneys' fees. Defendants again filed motions to dismiss, and they were granted on November 14, 2001. The District Court again ruled that the state law claims were preempted by ERISA, and also ruled that the ERISA causes of action did not state a claim for which the relief demanded by Petitioner could be granted.

An appeal was taken by Petitioner to the United States Court of Appeals for the Second Circuit which, on April 18, 2003, remanded the case for consideration in light of the then-recent decision in *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *cert. granted, vacated by Vytra Healthcare v. Cicio*, 542 U.S. 933 (2004), *remanded to Cicio v. Does*, 385 F.3d 156 (2d Cir. 2004). On remand, Defendants once again moved to dismiss and, on August 27, 2003, the District Court confirmed its earlier ruling and dismissed Petitioner's Amended Complaint a second time.

Petitioner filed a second appeal to the Second Circuit. After the opening briefs were filed, that Court granted Defendants' previously filed motion to stay and amended the schedule to permit further briefing and argument following the decision then pending before this Court in *Aetna Health Inc. v. Davila/Cigna Healthcare of Texas, Inc. v. Calad*, 542 U.S. 200 (2004). The latter decision was issued on June 21, 2004. Petitioner acknowledged that the *Davila/Calad* decision repudiated his contention that he could assert state law negligence claims seeking damages on the basis of a benefit coverage denial decision. He filed a Supplemental Brief on August 27, 2004, requesting that the Second Circuit remand the matter to the District Court so that he might file a new proposed Second

Amended Complaint asserting a claim for damages under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3) (2000). On January 31, 2005 the Second Circuit affirmed the District Court's dismissal of the First Amended Complaint, but remanded the case to allow Petitioner to again amend his complaint to assert a Section 502(a)(3) claim seeking damages as relief for the denial of coverage for the inpatient treatment.

A Second Amended Complaint was filed on May 31, 2005, asserting a claim under 502(a)(3), as well as two new counts purporting to be based on ERISA Section 404, 29 U.S.C. § 1104 (2000).[2] Defendants' subsequent motions to dismiss that complaint were granted, and the dismissal was affirmed by the Second Circuit on August 15, 2006. Petitioner has thus had his ERISA claims dismissed three times.[3]

Petitioner contends that this case is part of a "long judicial search for an ERISA remedy to permit beneficiaries to seek compensatory damages." (Pet.'s Br. 2-3). That no such search exists, or has ever existed, is confirmed by controlling, longstanding precedents. These precedents repeatedly affirm that ERISA's remedial structure accurately reflects the clearly expressed congressional determination that damages are not a permissible remedy under ERISA. Indeed, as detailed below, even when the Secretary of Labor, who is charged with the administration and enforcement of ERISA,[4] and the Solicitor General have argued to the Court that a damages remedy for plan participants and their beneficiaries should be inferred from the text of Section 502(a), this Court has rejected their arguments.

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[2] Section 404 does not provide any causes of action or forms of relief under ERISA.

[3] Thus contrary to Petitioner's assertion on page 3 of his brief, this is his fourth appeal.

[4] *See, e.g.*, ERISA §§ 502, 504, 505, 29 U.S.C. §§ 1132, 1134, 1135.

There are only a very few expressions, appearing in dissents and concurring opinions, that a damages remedy should, somehow, be conjured from the statute's unsupportive text. These isolated expressions appear against a backdrop of consistent and uniform rulings that Congress did not intend to allow for a damages remedy under ERISA. The Second Circuit's opinion below is but one more such unexceptional ruling.

SUMMARY OF ARGUMENT

The issue presented by the Petitioner has been litigated time and again, and its resolution is well settled by controlling precedent from this Court that has been consistently applied by the Circuit Courts, including the court below. There is no controversy among either the lower federal courts or the highest state courts regarding the meaning and effect of this Court's decisions governing the issue raised by Petitioner. That issue is whether the courts should engraft a new remedy onto Section 502 of ERISA that allows relief in the form of compensatory and other damages, notwithstanding Congress' express decision not to provide for such relief in ERISA.

Petitioner's claim that the lack of a damages remedy leaves him and others like him without effective relief when plan benefits are wrongly denied to them is specious. This Court has consistently held that Section 502(a)(1)(B) of ERISA provides the exclusive remedy for exactly such situations. Here, it was the Petitioner's election not to avail himself of that remedy that is the sole cause of his demand that all prior direct precedent be repudiated, and that a damages remedy be found to exist in ERISA.

Petitioner's contention that this Court, in its prior decisions confirming the unavailability of a damages remedy under ERISA, failed to understand the scope of equitable remedies available under the common law is without basis, and ignores a fundamental element of ERISA. That element is that Congress did not haphazardly incorporate into Section 502(a) of ERISA any and all equitable remedies available at common law, but

deliberately crafted a specific set of statutory remedies that were to be the exclusive remedies available to ERISA plan participants. There is no need to revisit established precedent that has properly given effect to congressional intent.

For these reasons, the Petition for a Writ of Certiorari should be denied.

REASONS FOR DENYING THE PETITION

I. PRINCIPLES OF *STARE DECISIS* REQUIRE THAT CERTIORARI BE DENIED IN THIS CASE

In decision after decision, this Court, as have lower federal courts, has adhered to the principle that ERISA does not afford compensatory damages under section 502(a)(3) of ERISA. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993). The law is well settled in this area, and Petitioner offers no good reason why this Court should now conclude that it has for decades grievously misunderstood the intent of Congress and, thus, misconstrued the scope of ERISA's remedial provisions in case after case. Petitioner's attempt to convince this Court to revisit and reverse its consistent prior decisions also is barred by the bedrock principles of *stare decisis* that this Court follows.

Stare decisis is one of the central principles of American jurisprudence. *Welch v. Tex. Dep't of Highways and Pub. Transp.*, 483 U.S. 468, 494 (1987). The doctrine literally means "to abide by the precedents and not to disturb settled points." *Ute Indian Tribe v. Utah*, 935 F. Supp. 1473, 1509 n.55 (D. Utah 1996). While this Court *may* depart from its prior holdings when necessary and appropriate, *stare decisis* prevents cases from being decided in an arbitrary fashion, and reflects the salutary principle that like cases should be treated alike. *Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989); *Flowers v. United States*, 764 F.2d 759, 761 (11th Cir. 1985). This Court has emphasized that "[*s*]*tare decisis* is the preferred course because it promotes the evenhanded, predictable, and consistent

development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process." *Payne v. Tennessee*, 501 U.S. 808, 827 (1991).

Deference to prior decisions is considered to be especially important in the area of statutory interpretation. *Neal v. United States*, 516 U.S. 284 (1996); *Patterson*, 491 U.S. at 172 (*stare decisis* has "special force in the area of statutory interpretation" because "the legislative power is implicated, and Congress remains free to alter what we have done"). This case squarely involves an issue of statutory interpretation and, absent truly compelling reasons, entirely absent here, this Court's prior decisions interpreting ERISA's remedial provisions should not be disturbed. Congress has never taken any actions that reasonably suggest that the Court's decisions are based on a misinterpretation of the intent of Congress with respect to the remedies available under Section 502(a).

II. SETTLED ERISA LAW PRECLUDES THE RELIEF PETITIONER SEEKS

A. Petitioner's Claims Are Actionable Solely Under Section 502(a)(1)(B) of ERISA

Plaintiff's core contention is that ERISA leaves plan participants and beneficiaries with no recourse when their plans are improperly administered and wrongful denials of benefits occur. He seeks to advance his contention by focusing on only one prong of ERISA's carefully crafted and comprehensive remedial scheme, Section 502(a)(3), while completely failing to acknowledge the existence of Section 502(a)(1)(B). This omission is deliberate, as the existence of Section 502(a)(1)(B) completely undermines Petitioner's argument.

In order to effectuate Congress' goal of protecting the interests of employee benefit plan members in obtaining the benefits their plans promise to them, Section 502(a)(1)(B) of ERISA empowers plan members to bring civil actions to obtain

those benefits when they have been improperly denied.[5] On its face, the text of Section 502(a)(1)(B) wholly contradicts Petitioner's core contention that ERISA does not provide a remedy for plan members who are wrongfully denied covered benefits, as it unambiguously provides express remedies for improper benefit coverage denials. In addition, Section 502(a)(1)(B) is the *exclusive* remedy for plan participants' claims based on benefit denials. *See Davila/Calad*, 542 U.S. at 210 ("[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely preempted by ERISA § 502(a)(1)(B)."). [6] This case involves only an allegedly improper benefit denial.

Any claim grounded upon an allegedly improper denial of a benefit due may only be brought under Section 502(a)(1)(B), and not under any other provision of ERISA. *See Varity Corp. v. Howe*, 516 U.S. 489 (1996) (equitable relief under Section 502(a)(3) is only available if no other remedy is available under ERISA; availability of recourse under Section 502(a)(1)(B) precludes seeking relief under Section 502(a)(3)). In this case, a single act is asserted to be the cause of all of Petitioner's injuries and is the basis of the damages he seeks to obtain; that act is the allegedly wrongful denial of coverage for inpatient treatment. Established precedent from this Court and lower courts compels the conclusion that *all* of Petitioner's entitlements to judicial relief therefore arise under Section 502(a)(1)(B) alone.

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[5] 29 U.S.C. § 1132(a)(1)(B) (2000) ("A civil action may be brought by a participant or beneficiary to *recover benefits* due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.") (emphasis added).

[6] Indeed, Petitioner asserted a Section 502(a)(1)(B) claim in his First Amended Complaint. It was dismissed because the relief he sought was not a benefit, but compensatory and punitive damages.

Petitioner not only seeks to have the Court repudiate its rulings that Section 502(a)(1)(B) provides the exclusive remedy for improper benefit denials, he also seeks to have the Court discard its well-established definition of what constitutes "equitable relief" under ERISA. Petitioner's stated rationale for asking this Court to reverse its definition of the scope of "equitable relief" permitted to plan participants under ERISA in order to allow damages to be classified as an equitable remedy is that he cannot be "made whole" under Section 502(a)(3) as currently construed.

The only reason Petitioner cannot now be made whole through ERISA's exclusive remedies, assuming for the sake of argument that he has been injured because the denial of inpatient treatment was improper, is that he failed to timely utilize his Section 502(a)(1)(B) remedy, and now has no need for coverage of the inpatient treatment that was denied. The relief provided by Section 502(a)(1)(B) had its optimal value at the time his treating physician believed that inpatient treatment was necessary. If Petitioner had sought relief under that provision at that time, and a court had determined that the denial of coverage for inpatient care was improper, he would have obtained a complete remedy including, potentially, an award of attorney's fees and costs pursuant to Section 502(g). 29 U.S.C. § 1132(g). *See, e.g., Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197 (10th Cir. 2002) (affirming award of attorney's fees to plaintiff in action for denial of benefits); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001) (discussed below); *Bailey v. Blue Cross & Blue Shield of Va.*, 67 F.3d 53 (4th Cir. 1996) (granting preliminary injunction for coverage of treatment sought); *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958 (8th Cir. 1995) (same).[7]

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[7] There are dozens of similar cases that have been decided by the federal courts; a more comprehensive listing of such cases can be found in the Addendum to Respondent's brief in opposition to Petitioner's appeal to the Second Circuit, filed February 17, 2006.

Alternatively, Petitioner could have preserved the full value of the Section 502(a)(1)(B) remedy even if he did not immediately file a lawsuit. All he had to do was follow his treating physician's advice and get the inpatient care. He could thereafter have brought an action under Section 502(a)(1)(B) against Empire and Merit. If the court determined that the denial of coverage was unjustified, he would recover both the costs of the care and his attorneys' fees and litigation costs. In sum, the Section 502(a)(1)(B) remedy, if timely sought or preserved, would have provided Petitioner with all of the relief he required and was entitled to receive. The sole reason the beneficial purpose of the Section 502(a)(1)(B) remedy could not be attained in this case is that Petitioner waited some three years after the coverage denial to seek judicial relief, and also elected not to go forward with the treatment his physician recommended.

The remedy provided by Congress to plan participants for wrongful denials is neither insufficient nor flawed in any manner when it is timely and properly pursued, either: a) at the time coverage for the medical services is denied; or b) after those services have been obtained. These options provide flexibility for the pursuit of this remedy. It is true that if a plan participant obtains the services that have been denied he becomes liable for their payment. The participant thus is exposed to the risk that there will be no reimbursement of that liability if a court subsequently determines that the plan fiduciary's denial was proper. There is no sensible reason to construe that result as either an injury to the participant, or as a wrongful act by the plan's claim fiduciary. The participant has received a service which the treating physician believed would be beneficial, and thus has received value for the obligation to pay for that service. The plan fiduciary, a court has determined, acted in the manner required by the plan documents which define and limit its discretion with respect to the coverage of benefits. There is no injury and there is no wrongful act.

No provision in ERISA expresses an intent by Congress to allow plan participants the choice of foregoing the timely

exercise of their Section 502(a)(1)(B) remedy in order to subsequently pursue a damages remedy for injuries resulting from the consequences of their failure to obtain the treatment recommended by their treating physician. The purpose of health care benefit plans is to enable plan participants to obtain covered benefits when their health status requires access to those benefits. This is the public good these plans strive to achieve, as evidenced by the text of ERISA. *See generally* ERISA § 2(a) (29 U.S.C. § 1001(a)) (noting the vital importance of employee pension and welfare benefit plans and the need to protect participants' expectancy interests) and § 2(b) (29 U.S.C. § 1001(b))

> "It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.".

In Section 502(a)(1)(B), Congress specifically created a remedy that would determine entitlement to coverage of benefits *expeditiously and when it mattered.* This remedy is consistent with the intent of Congress to assure the timely delivery of promised plan benefits to participants. Congress did not intend to have ERISA health benefit plans exposed to potentially enormous financial liabilities to participants and their lawyers because of *participants'* failures to timely pursue their remedies.

This Court very clearly described the options of plan participants who believe they have been wrongly denied a health benefit in *Davila/Calad.* "[R]espondents complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans. Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction." *Davila/Calad*, 542 U.S.

at 211. Other federal courts have similarly recognized that these are the only options available to ERISA plan members:

> Had Pryzbowski sought to accelerate U.S. Healthcare's approval of the use of out-of-network providers, she could have sought an injunction under § 502(a) to enforce the benefits to which she was entitled under the plan, thereby using the provisions of the civil enforcement scheme provided by Congress. There have been numerous cases in which the courts have issued preliminary injunctions under similar circumstances. *See, e.g., Marro v. K-III Communications Corp.*, 943 F. Supp. 247 (E.D.N.Y. 1996) (granting preliminary injunction to compel plan administrator to precertify high dosage chemotherapy); *Mattive v. Healthsource of Savannah, Inc.*, 893 F. Supp. 1559 (S.D. Ga. 1995) (granting preliminary injunction enjoining plan administrator from denying coverage for high-dose chemotherapy); *Dozsa v. Crum & Forster Ins. Co.*, 716 F. Supp. 131 (D.N.J. 1989) (granting preliminary injunction enjoining plan administrator from denying coverage for autologous bone marrow transplant treatment).

Pryzbowski, 245 F.3d at 273-274 . *See also* discussion and citations, *supra* pp. 10-11.

In the Solicitor General's amicus brief in *Davila/Calad*, the Government clearly stated the position that ERISA Section 502(a)(1)(B) provides an effective remedy for wrongful benefit denials:

> The balance Congress struck provides effective remedies for most claimants who *promptly and properly* seek them. First, under Section 502(a)(1)(B), Congress has allowed claimants to sue not just for benefits that are due, but also to enforce their rights under the plan and clarify rights to future benefits. Thus, a claimant may bring an action under Section

> 502(a)(1)(B) to challenge a pre-treatment denial of coverage by asking a court to order a managed care company (or other entity that administers a health plan) to pay for proposed treatment. *Successful claimants may be awarded attorneys' fees. District courts have been able to act quickly to provide relief to such claimants when necessary. See, e.g., Wilson v. Group Hosp. & Med. Servs., Inc.*, 791 F. Supp. 309 (D.D.C. 1992) (April 13, 1992 temporary restraining order prevented insurer from refusing to pay for April 14, 1992 treatment), *appeal dismissed*, 995 F.2d 306 (D.C. Cir. 1993); *White v. Caterpillar, Inc.*, 765 F. Supp. 1418 (W.D. Mo.) (action brought June 13, 1991; preliminary injunction issued June 26, 1991), *aff'd*, 985 F.2d 564 (8th Cir. 1991).

Davila/Calad, On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit, Brief for the United States as Amicus Curiae Supporting Petitioners, 2003 WL 23011479, at *26-27 (Dec. 18, 2003) (emphasis added) (citations omitted). Here, Petitioner asks this Court to: a) create a new remedy in ERISA for the benefit of plan participants who sit on their rights, fail to obtain the care that is the subject of a denial of coverage, and fail to pursue the specific and exclusive remedy created by Congress to deal with wrongful denials of covered benefits; and b) design that remedy so that the relief provided unambiguously constitutes damages, notwithstanding this Court's consistent rulings that only equitable remedies are available under ERISA. None of these demands presents an issue that is not disposed of by controlling precedent, or which is the subject of controversy in the courts.

B. Petitioner's Contention That ERISA's Remedial Scheme Enables Insurers to Take "Fraudulent Advantage" of Plan Participants Is a Baseless "Red Herring" Intended to Create the Appearance of an Issue That Is the Subject of Judicial Controversy.

In an unavailing effort to undermine the primacy of the Section 502(a)(1)(B) remedy with respect to claims of improper benefit denials, Petitioner looks to the dicta of Judge Becker in his *concurring* opinion in *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003), to the effect that ERISA's remedial scheme will create a "race to the bottom" by creating incentives for health plans to deny claims. There are two flaws in Petitioner's attempt to gain support from Judge Becker's statement. First, contrary to that dicta, the very purpose and intent of Section 502(a)(1)(B) is to timely prevent the potential adverse health effects of improper denials of covered health care services. It does so by providing for *immediate judicial relief* in the instance of a disputed denial of coverage. This remedy is beneficial from a health care perspective, as it operates to provide the contested health care benefits expeditiously if the denial is ruled to have been improper. Second, as previously demonstrated, the remedies which Petitioner says are supported by the referenced dicta require the failure by a participant to exercise available rights to challenge a denial of benefits and the deliberate failure to timely obtain the health care benefits in issue. It is that failure which is the cause of the adverse consequences to their health for which plan participants seek to recover damages. In effect, Petitioner is asking this Court to create a remedy that offers the prospect of a substantial economic rewards in exchange for elective conduct by plan participants that imperils their health.

The preceding result is absurd and is contrary to the clear intent of Congress to protect ERISA plans. Many of ERISA's remedies inure to the plans themselves and not to individual beneficiaries, thus reflecting congressional intent that the preservation of ERISA plans was a primary goal of the statute.

See, e.g., ERISA Section 502(a)(2) (allows suit against a plan fiduciary for breaches of fiduciary duty to the plan); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 (1985) (ERISA's drafters "were primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary."). Contrary to Petitioner's assertion that this Court in *Mertens* misconstrued basic equity law and gave insurers carte blanche to take "fraudulent advantage" of plan participants, the *Mertens* opinion reflects a realistic acknowledgment by the Court that it must balance Congress' dual goals of protecting both plan participants and the ERISA plans themselves.

If the Court were to grant Petitioner's demand for a damages remedy, ERISA plans, their fiduciaries, administrators and employer sponsors would be exposed to risks of large damage awards, and suffer the adverse effects of such risks and awards on the funding of plan benefits and costs of plan administration. Employers would find it more difficult to afford the costs of sponsoring ERISA benefit plans, and would either cease doing so or try to transfer more of those costs to plan participants. Insurers who provide fiduciary liability insurance would be compelled to increase their premiums to be commensurate with the expanded liability. Third Party Administrators and UM/UR managers, such as Merit in this case, also would be compelled to increase their charges to meet the additional costs and liability generated by the greatly expanded risk of substantial judgments. No one would benefit from the remedies Petitioner urges this Court to create other than plan participants who fail to exercise their Section 502(a)(1)(B) remedy and fail to obtain the care urged by their treating physicians and, of course, their counsel.

Because the purpose of ERISA is to ensure that beneficiaries would obtain the benefits promised to them, Congress deliberately and carefully crafted remedies that are "front-loaded." They are designed to ensure that plan participants can receive promised benefits *at the time they are most needed.* The provision for an award of attorneys' fees and costs provides

participants the means and the incentive for them to pursue that remedy expeditiously.[8] Congress could have created a "back end" remedy for plan participants, providing for damage awards after injuries have resulted from a failure to receive health services that should have been covered. In order for that remedial scheme to work, plan participants must elect not to receive the health care services at issue in order to suffer health consequences that will reap for them and their counsel a substantial financial award. Those consequences also would cause many more medical services to be required by the participants and paid for by their plans. Congress, wisely, did not create a remedy that would lead to such absurd and damaging consequences.

C. Clear Precedent Holds That Availability of Relief Under Section 502(a)(1)(B) Precludes *Any* Type of Relief Under Section 502(a)(3)

Consistent with the principle that Section 502(a)(1)(B) is the exclusive remedy for benefit denials, all directly applicable precedent uniformly holds that equitable relief under Section 502(a)(3) is *not* available to plan participants when their claims are predicated on a denial of benefits. This is the clear holding of this Court in *Varity*. There, the Court defined Section 502(a)(3) as a "catchall" provision "offering appropriate equitable relief for injuries caused by violations *that § 502 does not elsewhere adequately remedy*." *Varity*, 516 U.S. at 512 (emphasis added). This Court held that "where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.'" *Id.* at 515. The Court expressly ruled that the remedies available under Section 502(a)(1)(B) constituted just such a place where "Congress elsewhere provided adequate relief" for a claim seeking Section 502(a)(3) relief. *Id.*

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[8] *See* discussion, *supra* pp. 10-11.

The Second Circuit, in this case and in others,[9] as well as all other Circuit Courts which have ruled on the issue, have followed, as they must, the Court's clear ruling in *Varity* that, where Section 502(a)(1)(B) provides a specific remedy, relief may not be sought under Section 502(a)(3).[10] The force of this

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[9] *Frommert v. Conkright*, 433 F.3d 254 (2d Cir. 2006); *Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96 (2d Cir. 2005); *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76 (2d Cir. 2001); *Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90 (2d Cir. 2001).

[10] *See Johnson v. Buckley*, 356 F.3d 1067, 1077 (9th Cir. 2004) ("when relief is available under section 1132(a)(1), courts will not allow relief under 1132(a)(3)'s 'catch-all provision.'"); *Larocca v. Borden, Inc.*, 276 F.3d 22, 28 (1st Cir. 2002) ("federal courts have uniformly concluded that, if a Petitioner can pursue benefits under the plan pursuant to Section [502]a(1), there is an adequate remedy under the plan which bars a further remedy under Section [502](a)(3)"); *Estate of Bratton v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 215 F.3d 516, 526 (5th Cir. 2000) ("plaintiff in this purported § 502(a)(3) action is seeking only disability benefits allegedly due under the NUFI policy for which § 502 (a)(1)(B) affords an adequate remedy"); *Rhorer v. Raytheon Eng'rs & Constructors, Inc.*, 181 F.3d 634, 639 (5th Cir. 1999) ("[I]t is readily apparent from Rhorer's complaint that her claim to recover plan benefits is the predominate [sic] cause of action in this suit. Accordingly, because § 1132(a)(1)(B) affords Rhorer an avenue for legal redress, she may not simultaneously maintain her claim for breach of fiduciary duty."); *Tolson v. Avondale Indus.*, 141 F.3d 604 (5th Cir. 1998) (holding that because Petitioner had adequate relief available for the alleged improper denial of benefits through his right to sue directly under 502(a)(1)(B), relief through the application of 502(a)(3) was inappropriate); *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475 (9th Cir. 1997) (explaining that the Supreme Court in *Varity* "interpreted the statute to allow individual relief for a breach of fiduciary duty in an ERISA action only where no other adequate relief is available" and holding that "equitable relief under Section 1132(a)(3) is not 'appropriate' because Section 1132(a)(1) provides an adequate remedy in this case."); *Turner v. Fallon Cmty Health Plan, Inc.*, 127 F.3d 196, 200 (1st Cir. 1997)

> "Beneficiaries may sue a plan for breach of fiduciary duty causing individual harm, but . . . only for equitable relief and, even then, only where Congress has failed to provide more specific relief. Neither condition is met here since

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rule is such that it is enforced by the courts even when it is clear that a participant's claim under Section 502(a)(1)(B) would be, or has already been, unsuccessful, as in this case.[11] *See Ogden v. Blue Bell Creameries U.S.A., Inc.*, 348 F.3d 1284, 1287-88 (11th Cir. 2003) (Petitioner's claims were for recovery of benefits and, therefore, could not be brought under Section 502(a)(3) even though a Section 502(a)(1)(B) claim was barred by res judicata); *Katz v. Comprehensive Plan of Group Ins., ALLTEL*, 197 F.3d 1084, 1089 (11th Cir. 1999) (even an unrealized prospect of relief under Section 502(a)(1) makes relief under Section 502(a)(3) unavailable).

Petitioner repeatedly attempts to avoid casting his claim as one for a denial of plan benefits. His efforts are a transparent attempt at "artful pleading" designed to evade the clear remedial constraints of ERISA Section 502(a)(1)(B).[12] That his claim is

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> [Petitioner] seeks damages, not equitable relief, and *his grievance – a denial of benefits – is specifically addressed by 29 U.S.C. 1132(a)(1)(B)*."

(Emphasis added) (citation omitted); *Wald v. Sw. Bell Corp. Customcare Med. Plan*, 83 F.3d 1002, 1006 (8th Cir. 1996) (holding that petitioner asserting claim under 502(a)(1)(B) cannot also seek 502(a)(3) equitable relief); *Seales v. Amoco Corp.*, 82 F. Supp. 2d 1312, 1324-5 (M.D. Ala. 2000) ("equitable relief is not warranted for the § 502(a)(3) claim for breach of fiduciary duty because the Petitioners have an adequate remedy in the 502(a)(1)(B) claim for benefits. . . . [This is so] in spite of the fact that the finding leaves the Petitioners without a remedy for the breach."). *See also* James F. Jorden, et al., *Handbook on ERISA Litigation*, §4.04[1][c] n.130 (2d ed. 1996) ("No claim for breach of fiduciary duty is available when 502(a)(1)(B) affords a remedy").

[11] When Petitioner filed his Second Amended Complaint, the Second Circuit had affirmed the dismissal of the Section 502(a)(1)(B) claim asserted in his First Amended Complaint.

[12] Plaintiffs cannot evade the exclusive character of ERISA's remedial provisions by disguising ERISA benefit denial claims as fiduciary breach

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for a benefit that was denied is plain because, if his demand for inpatient treatment had been granted, this case would not exist, as Petitioner would not have had any claim to assert. A further logical proof that Petitioner's claim is solely predicated on a denial of a benefit is that, if a court were to rule that in his circumstances inpatient treatment was not a covered plan benefit, all of Petitioner's claims would be disposed of adversely to him.

The Petitioners in *Davila/Calad* also argued that they had never asserted a claim for denial of benefits. 542 U.S. at 206. In that decision, this Court could not have been more clear in affirming the principle that, if a claim is grounded on a benefit denial, regardless of how a plaintiff labels the claim, Section 502(a)(1)(B) provides the only remedy:

> [I]f an individual, *at some point in time, could have* brought his claim under ERISA 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is *completely preempted by ERISA § 502(a)(1)(B).*

Id. at 210 (internal citations omitted) (emphasis added). Petitioner's claim can *only* be pleaded under Section 502(a)(1)(B) because it rests solely on a benefit denial. *See also Varity*, 516 U.S. 489; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). Although it is clear that Petitioner's sole remedy is that provided by Section 502(a)(1)(B), he nonetheless asserts a claim for damages under Section 502(a)(3). That claim would be untenable even if, as a hypothetical matter, Section 502(a)(1)(B) were not his exclusive and sole available remedy.

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claims warranting equitable relief. *See Great-West Life*, 534 U.S. at 210 (plan participant cannot bring claim for monetary relief under 502(a)(3) by labeling it "equitable" in nature); *Gerosa v. Savasta & Co.*, 329 F.3d 317, 321 (2d Cir. 2003) ("In determining the propriety of a remedy, we must look to the real nature of the relief sought, not its label").

D. That Damages Are Not Available Under Section 502(a)(3) of ERISA Is Confirmed by All Applicable Precedent And Petitioner's Contention to the Contrary Does Not Raise a New or Controversial Issue.

If, hypothetically, a Section 502(a)(3) claim could be asserted by Petitioner, the relief he seeks pursuant to that provision is unattainable. Compensatory and other forms of damages are not available under Section 502(a)(3). That provision allows beneficiaries to seek *equitable* relief for fiduciary violations of both Title I of ERISA and of a plan's governing documents. It is settled law that such equitable relief does *not* include monetary damages.

This Court clearly defined the types of equitable relief available under Section 502(a)(3) in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), and plainly held that "appropriate equitable relief" is limited to relief that was:

> typically available in equity (such as injunctions, mandamus, and restitution, *but not compensatory damages*). . . . [L]imiting the sort of relief obtainable under § 502(a)(3) to 'equitable relief' in the sense of 'whatever relief a common-law court of equity could provide in such a case' would limit the relief *not at all*. We will not read the statute to render the modifier [i.e. "equitable"] superfluous.

Id. at 256-7 (emphasis in original). This Court thus ruled that damages are not an available remedy under ERISA Section 502(a)(3).

The *Mertens* holding was followed and refined nearly ten years later in *Great-West Life and Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002).

> "[I]n *Mertens* we rejected a reading of the statute that would extend the relief obtainable under § 502(a)(3) to whatever relief a court of equity is empowered to

> provide in the particular case at issue (which could include legal remedies that would otherwise be beyond the scope of the equity court's authority)."

Id. at 210.[13] *See also Gerosa v. Savasta & Co.*, 329 F.3d 317 (2d Cir. 2003). The Court thus made it clear in *Great-West* that the equitable relief available under ERISA *does not include forms of relief that the equity courts had adopted from the law courts* such as damages.

As should be expected, the lower federal courts have consistently followed this clear line of precedent. For example, in *Gerosa,* the Second Circuit held that "classic compensatory and punitive damages are never included within 'other appropriate equitable relief.'" 329 F.3d at 321 (citing *Great-West*, *Mertens*, and *Lee v. Burkhart*, 991 F.2d 1004, 1011 (2d Cir. 1993)). The *Gerosa* Court also accurately noted this Court's instruction that the courts are not free to create additional ERISA remedies:

> Twice in its most recent term, the Court has repeated its belief that ERISA's express remedies, as the product of long and careful study and compromise, should remain exclusive. We see little room in this framework for judicially-created, 'interstitial' remedies. . . . [W]e are no longer free to fill in unwritten gaps in ERISA's civil remedies. . . . [T]he Supreme Court has instructed

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[13] The Secretary of Labor urged the Court in *Mertens* to adopt an expansive interpretation of the relief available under Section 502(a)(3)that would allow for damages. *Id.* The Court rejected that attempt, finding that there was no basis for that interpretation. In *Great-West*, the United States again urged the Court to create an expansion of the equitable remedies under Section 502(a)(3), and was again rebuffed. The Government tried a third time in *Davila/Calad* to persuade the Court to create ERISA damage remedies that Congress did not intend, and once more did not succeed. Petitioner has not offered any new or better arguments than did the Solicitor General.

> that it is not for us to decide the best ERISA remedial scheme.

Id. at 322-23 (citations omitted).

Within the last year, at least four more Circuit Court decisions have been issued affirming the unavailability of monetary relief under Section 502(a)(3). *Frommert v. Conkright*, 433 F.3d 254 (2d Cir. 2006) (affirming District Court dismissal of the Petitioner's Section 502(a)(3) claim on the grounds that it was a disguised Section 502(a)(1)(B) claim, and that monetary relief — damages — is not a remedy available under Section 502(a)(3)); *Knieriem v. Group Health Plan, Inc.*, 434 F.3d 1058, 1063 (8th Cir. 2006) ("Knieriem seeks monetary relief that does not constitute 'other appropriate equitable relief' under section 1132(a)(3)(B)."); *Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96, 104 (2d Cir. 2005) (relief characterized as "restitution" was legal, and not equitable, in nature; "[w]e decline this invitation to perceive equitable clothing where the requested relief is nakedly contractual."); *Peralta v. Hispanic Bus., Inc.*, 419 F.3d 1064, 1076 (9th Cir. 2005) (relief not available under 502(a)(3) because "the only remedy sought is money").

Petitioner's primary argument in favor of allowing a damages remedy under ERISA centers on a purported exception to traditional equity remedial principles. Under those principles, this Court has ruled, money damages were not considered an appropriate remedy in equity, as such damages were the quintessential *legal* remedy. *Mertens*, 508 U.S. at 255 ("Money damages are, of course, the classic form of *legal* relief.") Petitioner contends, however, that there was one exception to this otherwise blanket prohibition that this Court overlooked. This exception applied to the circumstance in which no adequate legal remedy existed. (Pet.'s Br. 11-12.) In that instance, the equity courts could award damages if that were the only means by which to achieve a just result. *Id.*

Notably, Petitioner does not anywhere mention that there is readily available a complete remedy for the allegedly injurious

acts complained of in this case: a suit for benefits due under Section 502(a)(1)(B). Nor does he explain why his claimed exception to the equity principle that damages are not an available form of relief should even apply here to a claimant who sat on his rights and failed to obtain the care that, assertedly, would have prevented the very injuries for which damages are sought.

Petitioner further predicates his argument on the contention that Congress incorporated the common law of trusts into ERISA, and that monetary recoveries were available under that body of law. While it is true that ERISA incorporates many trust law concepts, Congress did not import *all* principles of trust law wholesale into ERISA. This is because while some trust law principles are applicable in a statutory employee welfare plan context, many others are not. The very authority cited by Petitioner in support of this argument concedes that this is the case.

> I do not mean to say that ERISA simply transposes trust law. To the contrary, *ERISA omits large swaths of traditional trust law* that are inapplicable to pension and employee benefit trusts. For example, having originated as a branch of the law of donative transfers, the law of trusts has been particularly attuned to the problems associated with successive estates (commonly life and remainder interests). By contrast, pension and employee benefit plan trusts are commercial arrangements arising from the employment relationship. *Congress had no need in ERISA to carry over doctrines of trust law that speak mainly to intrafamilial wealth transfer.* Likewise, structural differences between the private gratuitous trust and the employee benefit plan caused ERISA to depart from trust law in various ways.

Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103

Colum. L. Rev. 1317, 1327 (2003) (emphasis added). *See also Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 250 (2000) ("The common law of trusts . . . offers a '*starting point* for analysis [of ERISA] . . . [unless] it is inconsistent with the language of the statute, its structure, or its purposes"[14]) (citing *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447 (1999)) (emphasis added); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) ("ERISA's legislative history confirms that the Act's fiduciary responsibility provisions codif[y] and mak[e] applicable to [ERISA] fiduciaries *certain principles* developed in the evolution of the law of trusts.") (citing H. R. Rep. No. 93-533, p. 11 (1973)) (emphasis added) (internal citations and quotations omitted); *Donovan v. Mazzola*, 716 F.2d 1226, 1231 (9th Cir. 1983) ("in enacting ERISA *Congress made more exacting the requirements of the common law of trusts* relating to employee benefit trust funds") (citing *Sinai Hosp. of Baltimore v. Nat'l Benefit Fund for Hosp. & Health Care Employees*, 697 F.2d 562, 565 (4th Cir. 1982)) (emphasis added).

Petitioner argues that this Court, when it decided *Mertens*, wrongly disregarded the damages remedy provided by equity courts that he has discovered when it declined to craft a damages remedy under ERISA Section 502(a)(3). While there are a numerous flaws in Petitioner's argument, one is dispositive. That flaw is that his circumstances do not satisfy the predicate condition for an award of damages under his newly uncovered exception. The predicate condition of this exception is not satisfied here because Petitioner has always had a clear and express remedy for a wrongful denial of coverage of a claimed benefit. That remedy is Section 502(a)(1)(B). This case, therefore, does not require the Court to examine the issue whether it overlooked certain equitable remedies when it decided *Mertens*. Similarly, the Court has no reason to consider the issue

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[14] Here the common law of trusts as espoused by Petitioner is directly inconsistent with the provisions of ERISA Section 502(a)(1)(B).

whether courts of equity in fact provided damages as a form of relief on the basis of principles of equity and not by reason of their adoption of law court remedies.

There is further reason why this case does not require the Court to again examine the meaning of the term "equitable remedy." Even if Petitioner's analysis were sound that damages were a remedy purportedly available in courts of equity that was not imported from the courts of law, a damages remedy still would not be available under ERISA. This is because, as shown immediately hereafter, Congress clearly determined that damage remedies would not be available under ERISA.

E. This Court Has Already Determined That Congress Expressly Rejected Damages as an Available Remedy Under Section 502(a)(3).

Congress did not forget to provide for a damages remedy under ERISA, nor is the lack of any reference to such a remedy in Section 502 the result of negligent legislative draftsmanship.[15] An express congressional intent not to provide a damages remedy is clearly documented in the legislative history of the statute. That history reveals that, while an early version of the statute contained a provision for "legal or equitable" relief, described in both the Senate and House Committee Reports as authorizing "the full range of legal and equitable remedies

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[15] *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-48

> "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly. . . . In contrast to the repeatedly emphasized purpose to protect contractually defined benefits, there is a stark absence – in the statute itself and in its legislative history – of any reference to an intention to authorize the recovery of extracontractual damages."

(Emphasis added).

available in both state and federal courts,"[16] in the bill passed by the House of Representatives and ultimately adopted by the Conference Committee, *the reference to legal relief was deleted.*

Thus, when drafting ERISA, Congress crafted specific enumerated remedies – it did not simply import preexisting remedies from trust law. The remedial provisions in Section 502(a) were carefully crafted to provide recourse for individual participants in Section 502(a)(1), for the plan itself in Section 502(a)(2), and to address fiduciary conduct that affects all plan participants in Section 502(a)(3). Only Section 502(a)(1) is designed to provide relief for injuries to individual participants. Petitioner may lament the unavailability of "make-whole" relief to individual participants under Section 502(a)(3), but he cannot dispute that relief for individual participants' injuries is not the purpose of that statutory provision. Nor can he sensibly dispute that Section 502(a)(1)(B) is the clearly defined remedy for wrongful benefit denials. Section 502(a)(3) is not a supplement to 502(a)(1)(B) – these are distinct statutory provisions with distinct and unique purposes and, as explained above, are mutually exclusive.

To construe these two provisions otherwise would violate the statutory construction doctrine known as "expressio unius-est exclusio alterius." Pursuant to this doctrine, where a statutory provision expresses a single purpose, is made expressly applicable to a single subject, or provides for a specific remedy, all other purposes, subjects and remedies are deemed to be excluded from the effects or compass of the provision. *Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 168 (2003) (explaining that the doctrine has force when items expressed are "members of an associated group or series, justifying the inference that items not mentioned were excluded by deliberate choice, not inadvertence"); *United States v. Vonn*, 535 U.S. 55, 65 (2002)

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[16] *See* H.R. Rep. No. 93-533, at 17 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4655; S. Rep. No. 93-127, at 35 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4871.

("expressing one item of [an] associated group or series excludes another left unmentioned"); *Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81 (2002) (regulation held invalid because it supplemented existing remedial scheme set by Congress in statute and decision by Congress to provide for one remedy indicates that it did not intend for the creation of any others).

While ERISA is grounded in common law principles drawn from trust law and equity, it is nonetheless a statutory regime in which Congress expressed its intentions to protect both plan participants and ERISA plans themselves. Congress thus constructed a remedial scheme designed to achieve both of these purposes. Petitioner has pursued a fruitless string of appeals seeking a judicial interpretation that would radically depart from established precedent and the express intent of ERISA itself. If new remedies are to be grafted onto ERISA's existing remedial scheme, it will be up to Congress to undertake that task. Petitioner's quixotic quest to obtain that result through the courts should end here.

CONCLUSION

Petitioner has failed utterly to provide the Court with any reason to grant his Petition, as this case does not involve issues in which conflicts exist in the lower courts, and it does not present any unresolved or significant questions of law for which the lower courts need guidance. For the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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